

## YALE-NEW HAVEN HOSPITAL IMMUNIZATION TESTING RECORD

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_  
 DEPARTMENT: \_\_\_\_\_ DATE: \_\_\_\_\_

<b>DOCUMENTATION OF IMMUNIZATIONS/TITERS</b>		
	<u>DATE</u>	<u>RESULT</u>
RUBEOLA VACCINE		
RUBEOLA TITER (if no vaccine)		
RUBELLA VACCINE		
RUBELLA TITER (if no vaccine)		
MMR VACCINE		
Have you had the chickenpox?		
YES _____ NO _____		
VARICELLA TITER (if done)		
VARICELLA VACCINATION (if done but not required)		
PPD, MANTOUX (within the last year, if PPD-Negative)		

If **PPD** positive, did you have a chest x-ray:

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

If **PPD** positive, did you receive prophylactic anti-tuberculous therapy:

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

Have you received the **Hepatitis B** Vaccine series:

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

What was the result of your **Hepatitis B** surface antibody test following the vaccine series:

**POSITIVE** \_\_\_\_\_ **NEGATIVE** \_\_\_\_\_